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| R000000 | This visit was for a State Residential Licensure Survey.<br><br>Survey dates: December 19 & 22, 2014<br><br>Facility number: 012706<br>Provider number: 012706<br>AIM number: N/A<br><br>Survey Team:<br>Angela Patterson, RN-TC<br>Susan Worsham, RN<br>Cheryl Mabry, RN<br>Brooke Harrison, RN (12/22, 2014)<br>Kimberly Gines, RN (12/22, 2014)<br><br>Census bed type:<br>Residential: 54<br>Total: 54<br><br>Census Payor type:<br>Total: 0<br><br>Residential sample: 7<br><br>These state findings are cited in accordance with 410 IAC 16.2-5.<br><br>Quality review completed on December 26, 2014; by Kimberly Perigo, RN. | R000000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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| R000121 | 410 IAC 16.2-5-1.4(f)(1-4)<br>Personnel - Noncompliance<br>(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following:<br>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>(3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings.<br>(4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight | | | |

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| | loss) shall not be permitted to work until tuberculosis is ruled out.<br>Based on interview and record review, the facility failed to ensure staff obtained tuberculosis testing as indicated by facility policy for 10 of 10 current employees reviewed for tuberculosis testing. (CNA (Certified Nursing Assistant) #3, CNA #4, CNA #5, Housekeeper #1, Dietary Aide #6, CPA (Certified Personal Accountant) #1, LPN #1, LPN #2, QMA (Qualified Medication Aide) #20, and RN #2)<br><br>Findings include:<br><br>The employee records list and records were provided by the Business Office Manager on 12/22/14 at 9:00 a.m.<br><br>Review of the employee records indicated 5 newly hired employees failed to have a completed second step tuberculosis testing (CNA #3, CNA #5, Housekeeper #1, CPA #1, and QMA #20) and 5 employees failed to have a completed annual tuberculosis test (CNA #4, LPN #1, LPN #2, RN #2 and Dietary Aide #6).<br><br>During an interview on 12/22/14 at 1:30 p.m., the DON (Director of Nursing) indicated she could not find any tuberculosis testing results for CNA #4, | R000121 | All current staff will be brought current with 2 step method via administration by Autumn Hills nursing staff by January 31, 2015. Further, and effective immediately, new hires will not be allowed to work prior to first step being completed. New tracking log developed as of January 1, 2015. Implementation and tracking for 2nd step to be done by Business Office Manager and Administrator via reminders set up within computer applications. Quality Assurance meeting to be held by Administrator, Health Services Director, Business Office Manager, and Community Resources Director the last week of every month to review new hire tuberculosis testing is compliant. | 01/31/2015 |

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| | LPN #1, LPN #2, RN #2, or Dietary Aide #6. The DON also indicated she called the other newly hired employees today to restart the two step tuberculosis testing process.<br><br>On 12/22/14 the DON provided the October 2014, through December 2014, "Nursing" and "CNA" work schedules.<br><br>The schedules from October 2014, up to December 22, 2014, indicated the following:<br><br>QMA #20 worked 23 days in October, 20 days in November, and 16 days in December.<br><br>RN #2 worked 1 day in October, 2 days in November, and 1 day in December.<br><br>LPN #2 worked 1 day in December.<br><br>CNA #4 worked 8 days in October, 13 days in November, and 13 days in December.<br><br>CNA #5 worked 17 days in October, 18 days in November, and 14 days in December.<br><br>CNA #3 worked 14 days in October, 12 days in November, and 10 days in December. | | | |

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| | LPN #1 worked 16 days in November and 16 days in December.<br><br>The tuberculosis testing results were not current while the employees continued to work during these shifts.<br><br>The "TB Testing Policy-Employees" was provided by the Administrator on 12/22/14 at 2:00 p.m. The Administrator indicated the policy was current. The policy indicated, "...At the time of employment, or within one month prior to employment, and annually, employees should be screened for tuberculosis. Employees should have the two-step method used if the workers had no documented negative tuberculin skin test result in during the preceding twelve months." | | | |
| R000217 | 410 IAC 16.2-5-2(e)(1-5)<br>Evaluation - Deficiency<br>(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows:<br>(1) The services offered to the individual resident shall be appropriate to the:<br>(A) scope;<br>(B) frequency;<br>(C) need; and | | | |

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| | (D) preference;<br>of the resident.<br>(2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review.<br>(3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request.<br>(4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services.<br>(5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.<br>Based on interview and record review the facility failed to ensure a service plan was developed for residents as the facility policy indicated for 3 of 7 residents whose clinical records were reviewed. (Resident #1) (Resident #2) (Resident #3)<br><br>Findings include:<br><br>1. The clinical record of Resident #1 was reviewed on 12/19/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to: dementia and Alzheimer's disease.<br><br>The clinical record lacked a completed service plan for Resident #1. A copy of the service plan, received on 12/19/14 at | R000217 | Service plans for 3 residents (#1, 2, & 3) are completed as of 12/19/2014. Going forward, and effective immediately, service plans are being completed after the initial assessment for a potential resident by the Health Services Director and prior to the resident's admission.<br>Quality Assurance meeting to be held by Administrator, Health Services Director, Business Office Manager, and Community Resources Director the last week of every month to review service plans are compliant. | 12/22/2014 |

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| | 12:05 p.m., printed by the DON on 12/19/14 at 11:59 a.m., indicated Resident #1 was admitted on 10/22/14. The service plan only contained information of Resident #1's communication, mobility, falls, dressing, and grooming. No other plans had been implemented..<br><br>Interview on 12/19/14 at 12:05 p.m., DON indicated there was no completed service plan for Resident #1.<br><br>2. Resident #2's clinical record was reviewed on 12/19/14 at 11:00 a.m. Diagnoses included, but were not limited to: dementia with behaviors.<br><br>Resident #2 was admitted on 10/20/14.<br><br>On 12/19/14 at 10:00 a.m., review of Resident #2's clinical record indicated there was no service plan. The Director of Nursing indicated there was a service plan started for Resident #2, but It was incomplete. When request for a copy of the portion that was completed, the DON indicated, "I am not able to print, but it is not complete."<br><br>On 12/19/14 at 11:55 a.m., an interview with the Administrator indicated with HSD (Health Service Director) had not completed the service plans for Resident | | | |

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| | #2.<br><br>3. Resident #3's clinical record was reviewed on 12/10/2014 at 10:00 a.m. Diagnoses included but, were not limited to dementia.<br><br>Resident #3 was admitted to the facility on 11/3/2014.<br><br>On 12/19/2014 at 11:00 a.m., review of the facilities service plan book for the residents indicated no service plan for Resident #3.<br><br>On 12/19/2014 at 11:25 a.m., an interview with Health Services Director (HSD) indicated Resident #3's service plan was not in the binder yet so she would print it out.<br><br>On 12/19/14 at 11:55 a.m., an interview with the Administrator indicated with HSD had not completed the service plans for Resident #3.<br><br>On 12/23/14 at 2:55 p.m., an interview with the HSD indicated she thought she had 30 days to complete a service plan.<br><br>On 12/19/14 at 12:19 p.m., the DON provided policy "Resident Service Plan", undated, and indicated it was the one currently used by the facility. The policy | | | |

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| | indicated, "...An individualized service plan, addressing all needs identified during the initial assessment, will be completed for each resident, prior to admission...utilized in developing the plan to ensure that the plan addresses the personal care, nursing, dietary, activity, mental, emotional and environmental needs of the resident. ... PROCEDURE: 1). Based on the initial assessment conducted prior to admission, and initial service plan will be developed. ... will be reviewed within 14-30 days of admission, ....3. ... updated at least every 3 months for dementia care residents and every 6 months for assisted living, ...." | | | |
| R000273 | 410 IAC 16.2-5-5.1(f)<br>Food and Nutritional Services - Deficiency<br>(f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24.<br>Based on observation, interview, and record review, the facility failed to ensure proper handwashing was completed upon entering the kitchen and handling food | R000273 | 410 IAC 7-24 printed and made available to kitchen staff as of January 1, 2015. Also, Administrator reviewed findings from survey with dietary staff | 01/14/2015 |

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| | products, the ice scoop was stored in a closed container, food was discarded from 1 of 1 dry storage room, 1 of 1 walk in freezer and 1 of 1 reach in refrigerator when the expiration date had passed as indicated by facility policy and Center for Disease Control. This deficient practice had the potential to affect 55 of 55 residents being served out of the kitchen.( Dietary Aide #1 (DA), Food Service Director(FSD) )<br><br>Findings include:<br><br>On 12/22/14 at 9:09 a.m., the following were observed during the kitchen tour in the dry storage room:<br><br>1). On a shelf, inside a empty exam gloves box there was an opened 25 pound bag of Argon cornstarch. There was starch over the top outside portion of the bag.<br><br>2). On a shelf, inside a cardboard box there was a opened 50 pound bag of cocoa.<br><br>The FSD indicated when asked what is wrong with the bag of starch and cocoa, "It has stuff sticking out, it's open without a date." When asked what is the shelf life for food in the dry storage room, "Six months." | | paying particular attention to labeling, handwashing, and cleanliness of staff and equipment. Closed ice scoop container in place as of January 8, 2015. Food items noted in survey within freezer, refrigerator, and dry storage have been discarded appropriately either at time of survey and/or as of 12/31/14. New Food Service Director in place effective January 13, 2015. Contract with consulting Registered Dietician to be in place by February 1, 2015 for monthly visits to oversee dining services. Administrator and Health Services Director to conduct handwashing and glove usage in-service at next all-staff meeting scheduled on January 14, 2015. Distributed CDC guidelines on handwashing and 410 IAC 7-24 on glove use. Handwashing and glove use will be reviewed at every other all-staff meeting for 6 months. Also will be observed by Registered Dietitian starting in February 2015. | |

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| | 3). A large brick of hard substance without a label or open date. The FSD indicated that was white chocolate. When asked if the hard substance was identifiable without label. The FSD indicated, "yes, but it should be identifiable." The FSD was observed at that time to label the white chocolate.<br><br>4). A large bin with a bag of sugar was observed to have a measuring cup/scoop stored inside the bag. The FSD was observed to remove, at that time. The FSD indicated the cup/scoop should not have been in the bag of sugar.<br><br>5). There were two loaves of bread opened and undated on the shelf . The FSD was observed to remove and discard at that time.<br><br>6). There was an opened, undated bag of powder sugar on the shelf. The FSD was observed to take the powder sugar out of the dry storage room.<br><br>On 12/22/14 at 9:40 a.m., the following was observed in the kitchen with the FSD present:<br><br>7). Two cups for a bullet blender were observed dirty on a cart by the dry storage door. The FSD was observed to rub one | | | |

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| | cup and indicated, "Oh, yes this is dirty. Oh that is cocoa. I use these cups for spices." The FSD was observed to remove cups and take to Dietary Aide (DA) #1.<br><br>8). The stand up mixer was observed to be dirty around the top where the beater attaches. When asked if this mixer had been used today the FSD indicated, "No." The FSD indicated that the mixer was dirty.<br><br>9). There were 4 dirty rubber spatulas observed in a drawer in the kitchen. The FSD was observed to remove all the spatulas and give to DA #1 to wash. There were 2 spatulas observed damaged. The FSD was observed to discard at that time.<br><br>10). There was an ice scoop uncovered lying on a ledge on the outside of the ice machine. The ledge was observed to be dusty and dirty. The FSD indicated when asked if the ice scoop should be uncovered and on the ledge, "Since I've been here that is where it's always been. I was told it goes there as long as it is facing down." When asked if the ledge was clean the FSD indicated, "Not right now. It doesn't look clean."<br><br>On 12/22/14 at 10:10 a.m., the following | | | |

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| | was observed in the walk in freezer with the FSD present:<br><br>11). A container labeled zucchini dated 2/24/14, was observed with frost on it.<br><br>12). A large baggie labeled chicken and dumpling dated 3/15/14.<br><br>13). A container labeled tuna with a open date of 3/27/14, and expiration dated of 3/30/14.<br><br>On 12/22/14 at 10:20 a.m., the following was observed in the reach in refrigerator:<br><br>14). A bag of dry yeast open and undated.<br><br>15). A open container of strawberry syrup undated. The container was dirty with what appeared to be mold on the container lid. The FSD indicated when asked what was on the container, "That is gross and it has mold on it." Observed the FSD to remove at that time.<br><br>16). A large jar of grape jelly opened 2/19/14, and dirty. The FSD indicated that should have been used in a month. Observed the FSD to discard at that time.<br><br>17). On 12/22/14 at 11:50 a.m., observed DA #1 to open the kitchen door with bare hands, lock the door, walk over to the | | | |

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| | counter and open the drawer to remove a clean towel. He was then observed to walk over to open the dish washer and remove a clean dish tray. DA #1 was observed to walk back into the kitchen, open a drawer and remove a towel. He walked over to the dirty dish area, wiped down the sink counter, and loaded a tray of dirty dishes into the dishwasher. No handwashing was observed. DA #1 was observed to wash a large spoon and bring to the FSD. DA #1 walked over to the dishwashing area removed 3 trays of cups and take into the kitchen area. No handwashing was observed.<br><br>18). On 12/22/14 at 12:00 p.m., observed the FSD to lift his leg and open the oven handle with his foot and place the pork into the oven. When asked if he should be opening the oven with his foot. The FSD indicated, "I guess not." When asked if he had just contaminated the handles on the oven. The FSD indicated, "Yes." The FSD was observed to wipe the handle of the oven at that time.<br><br>19). On 12/22/14 at 12:10 p.m., observed DA #1 to scratch his head then proceed to roll silverware in a napkin. When asked what he had just done, DA #1 indicated, "Oh, I just thought about that before you asked me that." DA #1 was observed to handwash at that time for 5 | | | |

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| | seconds. He then continued to roll the silverware. The FSD was made aware at that time. The FSD indicated to DA #1 to discard the silverware that he had presently rolled.<br><br>20). On 12/22/14 at 12:15 p.m., observed Activity staff to enter the kitchen and assist DA #1 rolling silverware. No handwashing was observed. When asked what should she do upon entering the kitchen, the Activity staff indicated, "I was outside the kitchen and washed my hands. I didn't know that I had to wash once I entered the kitchen if I washed before entering." When asked what does the facility policy indicated, the Activity staff indicated, "I don't know."<br><br>21). On 12/22/14 at 12:45 p.m., RN #1 was observed to pick food up off the floor and place in the trash can. She then walked over to the sink in the dining room, turned on the sink and wet her hands. There was no observation of soap being used and rinsed for 4 seconds. RN #1 was observed to walk around the dining room. She got a glass of lemonade for a potential resident who was visiting the facility. RN #1 was observed to pull down on the back of her scrub top, pick up a container of butter off the floor, walk over to Resident #12, and move Resident #12's tea to the other | | | |

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| | side of Resident #12's plate. No handwashing was observed. RN #1 walked over to a table to get a bowl of butter and place in from of Resident #15.<br><br>She then went over and got a rolling walker for Resident #14 and assisted Resident #14 out of the dining room. RN #1 entered the dining room removed a empty cup from Resident #13, walk over to the counter and poured a cup of milk for Resident #13. No handwashing was observed. When asked when should she handwash RN #1 indicated, "Before entering the dining room, before taking away one plate, after touching clean dishes, before giving someone a drink, if someone drops something on the floor and when touching things." When asked was that done, RN #1 indicated, "No, I did not." When asked how long should she handwash for, RN #1 indicated, "We should handwash 30 seconds to 1 minute. Is that not long enough." When asked what the facility policy said, RN #1 indicated, "I don't know." When asked if she handwashed for 30 seconds, RN #1 indicated, " Yes, didn't I."<br><br>On 12/22/14 at 1:14 p.m., the Administrator provided policy "DIETARY HANDWASHING POLICY" undated, and indicated that was the one currently used by the facility. | | | |

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| | The policy indicated, " ..3. Wash for 20 seconds, ...before starting work, ... after touching anything that might result in contamination of hands. ..."<br><br>On 12/22/14 at 1:15 p.m., the Administrator provided documentation labeled "When to Wash Hands" undated, and indicated that was what the facility currently used. The documentation indicated, "...Touching the hair, face, or body., ...Touching clothing or aprons., ... Leaving and returning to the kitchen/prep area., ... Touching anything else that may contaminate hands, such as dirty equipment , work surfaces, or cloths. ..."<br><br>On 12/22/14 at 11:21 a.m., the Administrator provided policy "Thawing Foods and Use of Leftovers Inservice" undated, and indicated that was the one currently used by the facility. The policy indicated, " ...2. d. Leftovers not used within 48 hours shall be frozen. Frozen leftovers shall be utilized within a 6 month period. ..."<br><br>On 12/22/14 at 11:21 a.m., the Administrator provided policy "Dry Food Storage Inservice" undated, and indicated that was the one currently used by the facility. The policy indicated, " ...Containers ...fitting covers, label top and side for storing dry products, ... | | | |

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| | Scoops: Scoops are not to be used for flour, sugar, cereals, ...Scoops are not to be stored in food containers, but are to be kept covered in a bag or container nearby. ..."<br><br>On 12/23/14, review of Center for Disease Control at ww.cdc.gov/handwashing/, dated December 16, 2013 indicated, " When should you wash your hands?<br>Before, during, and after preparing food<br>Before eating food<br>Before and after caring for someone who is sick<br>Before and after treating a cut or wound<br>After using the toilet<br>After changing diapers or cleaning up a child who has used the toilet After blowing your nose, coughing, or sneezing<br>After touching an animal, animal feed, or animal waste<br>After handling pet food or pet treats<br>After touching garbage<br>How should you wash your hands? Wet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. Scrub your hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice. ... " | | | |

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| R000410 | 410 IAC 16.2-5-12(e)(f)(g)<br>Infection Control - Noncompliance<br>(e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read.<br>(f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis.<br>(g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis.<br>Based on interview and record review, the facility failed to ensure residents received second step tuberculin skin test as the facility policy indicated for 2 of 7 resident whose clinical records were reviewed. (Resident #3, Resident #6)<br><br>Findings include:<br><br>1. Resident #3's clinical record was reviewed on 12/10/2014 at 10:00 a.m. Diagnoses included but, were not limited to dementia. | R000410 | All current residents have had the two-step method for tuberculosis testing completed as of January 5, 2015 by our nurses. Residents or families who refused were complete with a chest x-ray. Going forward, new residents will receive the first step no later than the time of admission. This is now a part of our admission paperwork along with Physician Assessments and chest x-rays. Second steps will be done within the required one to three week time frame. The new electronic Medication Administration Record system that will be in place by February 1, 2015 will be utilized to | 01/05/2015 |

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| | Resident #3 was admitted to the facility on 11/3/2014.<br><br>Resident #3's clinical record lacked documentation of a completed second step tuberculin test.<br><br>On 12/22/2014 at 9:30 a.m., an interview with the HSD (Health Services Director) indicated Resident #3 had not received her second step tuberculin (TB) test. At that time, the HSD indicated Resident #3 tuberculin skin testing had been started over since the second step TB test had not been completed.<br><br>On 12/22/2014 at 9:35 a.m., requested copy of immunization record for Resident #3, the HSD did not provide a copy.<br><br>2. Resident #6's closed clinical record was reviewed on 12/22/2014, at 1:00 p.m. Diagnoses included but, were not limited to dementia.<br><br>On 12/22/2014 at 9:50 a.m., an interview with HSD (Health Services Director) indicated Resident #6 admitted on 8/18/2014, and was discharged to another facility on 10/31/2014. No documentation in the clinical record of the second step tuberculin skin test (TB). | | track this accordingly.<br>Quality Assurance meeting to be held by Administrator, Health Services Director, Business Office Manager, and Community Resources Director the last week of every month to review tuberculosis testing is compliant. | |

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| | On 12/22/2014 at 1:32 p.m., an interview with HSD indicated she was waiting on the doctor's office for Resident's 6's TB (tuberculin) results.<br><br>On 12/22/2014 at 1:00 p.m., asked the HSD to provide a copy of Resident #6's immunization record.<br><br>On 12/22/2014 at 2:10 p.m., the HSD provided Resident 6's immunization record from the facility the resident discharged to. The immunization record indicated Resident #6 received a first step TB test on 10/31/2014, and a second step on 11/16/2014.<br><br>On 12/22/2014 at 2:00 p.m., the HSD provided the TB Testing Policy-Residents, undated, and indicated the policy was the one currently being used by the facility. The policy indicated "...upon admission and read at forty-eight (48) to seventy-two (72) hours..." | | | |
| R000414 | 410 IAC 16.2-5-12(k)<br>Infection Control - Deficiency<br>(k) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | | | |

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| | Based on observation, interview, and record review, the facility failed to ensure staff changed contaminated gloves during food distribution. (CNA #1 and CNA #2)<br><br>Findings include:<br><br>1) During a main dining room observation on 12/22/14 at 12:32 p.m., Resident #8 grabbed CNA (Certified Nursing Assistant) #1's gloved hand and pulled it to her face. CNA #1 proceeded to hand out silverware and cut up food for Resident #9. The CNA then removed the gloves and left the dining room without washing hands.<br><br>2) During an observation on 12/22/14 at 12:45 p.m., CNA #2 repositioned Resident #10's wheelchair with gloved hands. She then handed out clean silverware and drinks to Resident #10 and Resident #11.<br><br>During an interview on 12/22/14 at 12:55 p.m., CNA #2 indicated staff should change gloves after busing a table.<br><br>During an interview on 12/22/14 at 1:00 p.m., CNA #1 indicated he was unsure of when staff was to change gloves. He also indicated staff should wash their hands before they serve or touch the residents. | R000414 | Administrator and Health Services Director to conduct handwashing and glove usage in-service at next all-staff meeting scheduled on January 14, 2015. Distributed CDC guidelines on handwashing and 410 IAC 7-24 on glove use. Handwashing and glove use will be reviewed at every other all-staff meeting for 6 months. Also will be observed by Registered Dietitian starting in February 2015. | 01/14/2015 |

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| | On 12/22/14 at 1:15 p.m., the Administrator provided "Autumn Hills Glove Usage and Hand Washing" policy and procedure. The policy indicated staff should change gloves if they become contaminated. | | | |